Magnolia Reviews of Texas, LLC

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Date notice sent to all parties]:

03/22/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Transforaminial Lumbar Epidural Steroid injection at right L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Anesthesiology
Board Certified Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury XX/XX/XX, which occurred when he was struck by a car. Diagnoses included back pain with radiation, lumbar intervertebral disc displacement without myelopathy, chronic pain syndrome and lumbago. Treatment to date has included the use of medications, physical therapy, and the use of a TENS unit. Submitted records indicate that the patient underwent an MRI of the lumbar spine performed on XX/XX/XX which revealed an L5-S1 facet joint hypertrophy with 5 mms intradiscal herniation which mildly indented the thecal sac with mild left neural foraminal stenosis and no significant right neural foraminal stenosis. The patient's medications were noted to include cyclobenzaprine, Medrol dose pack, Naproxen, Norco, tramadol, and Zanaflex. There is no indication of relevant surgical history. According to the notes submitted for review dated XX/XX/XX, the patient was seen

for evaluation with complaints of lower back pain radiating down the posterior aspects of the left to the toes with associated numbness/tingling and weakness. Physical examination revealed no spinal tenderness and no pain with facet loading. A bilateral straight leg raise was positive. Spinal range of motion was normal but the patient had pain with flexion. There was weakness present with dorsiflexion and plantarflexion to the right lower extremity and left lower extremity. Deep tendon reflexes were normal at 2 and sensation was noted to be reduced to light touch at the right L4-5 dermatomal distribution. It was recommended that the patient undergo a transforaminal epidural steroid injection at L5-S1.

The requested treatment was previously denied as the dermatomal level on examination did not correlate with the level being requested, and there was no evidence that the patient would be participating in an active therapy program along with the injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

According to the Official Disability Guidelines, epidural steroid injections may be supported for patients who have radiculopathy which is documented with objective findings on examination, corroborated by imaging studies and/or electrodiagnostic testing, when patients are initially unresponsive to conservative treatment. The records submitted for review indicate that the patient has been recommended to undergo an epidural steroid injection at this time; however, the clinical records submitted for review provided no clear documentation that the patient would be undergoing any active therapy in conjunction with injection therapy. The clinical records submitted for review also note that the patient underwent an MRI of the lumbar spine on XX/XX/XX; however, the official report was not submitted for review. The noted MRI results also showed no significant findings at the L5-S1 level which indicated nerve root compression to support an epidural steroid injection at this time. There was no documentation of any exceptional factors or unique clinical circumstance to warrant treatment with the requested service outside of guideline recommendations. Given all of the above, the prior denial for transforaminal epidural steroid injection at right L5-S1 is upheld.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES, 14th Edition (web), 2016, Low Back, Epidural steroid injections (ESIs), therapeutic**